		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022947

Facility Name: Pershing Estates

Address: 1016 W. Pershing Rd (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: 217-875-0833 **Fax #** 217-875-6851

IDPA ID Number: 370969602002

Date of Initial License for Current Owners: 12-01-1976

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Denise King **Telephone Number:** 217-429-2500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2004 to 12-31-2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 4-29-05 (Date)
(Type or Print Name) Denise King
(Title) Corporate Secretary

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	137	Intermediate (ICF)	137	50,142	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,142	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	42,456	390	1,993	44,839	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,456	390	1,993	44,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.42%

D. How many bed-hold days during this year were paid by Public Aid?
594 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/1976

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2004 **Ending:** 12-31-2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	133,702	1,350	9,703	144,755		144,755		144,755			1
2	Food Purchase		1,061		1,061	(261)	800		800			2
3	Housekeeping	115,714			115,714		115,714		115,714			3
4	Laundry											4
5	Heat and Other Utilities			80,696	80,696		80,696		80,696			5
6	Maintenance	33,519	26,172	65,656	125,347		125,347		125,347			6
7	Other (specify):* Resident workers	27,334			27,334		27,334		27,334			7
8	**TOTAL General Services**	310,269	28,583	156,055	494,907	(261)	494,646		494,646			8
	B. Health Care and Programs											
9	Medical Director			30,389	30,389		30,389		30,389			9
10	Nursing and Medical Records	682,393	29,790	1,350	713,533		713,533		713,533			10
10a	Therapy											10a
11	Activities	51,076	4,597	1,200	56,873		56,873		56,873			11
12	Social Services	98,045		1,910	99,955		99,955		99,955			12
13	Nurse Aide Training											13
14	Program Transportation		8,861		8,861		8,861		8,861			14
15	Other (specify):* MI Programmers	31,049			31,049		31,049		31,049			15
16	**TOTAL Health Care and Programs**	862,563	43,248	34,849	940,660		940,660		940,660			16
	C. General Administration											
17	Administrative	364,811			364,811		364,811		364,811			17
18	Directors Fees											18
19	Professional Services			11,920	11,920		11,920		11,920			19
20	Dues, Fees, Subscriptions & Promotions			14,083	14,083		14,083	(650)	13,433			20
21	Clerical & General Office Expenses	81,999	29,135	19,181	130,315		130,315	(6,179)	124,136			21
22	Employee Benefits & Payroll Taxes			206,802	206,802	261	207,063		207,063			22
23	Inservice Training & Education			3,319	3,319		3,319		3,319			23
24	Travel and Seminar			2,978	2,978		2,978		2,978			24
25	Other Admin. Staff Transportation			3,301	3,301		3,301		3,301			25
26	Insurance-Prop.Liab.Malpractice			75,598	75,598		75,598		75,598			26
27	Other (specify):*											27
28	**TOTAL General Administration**	446,810	29,135	337,182	813,127	261	813,388	(6,829)	806,559			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,619,642	100,966	528,086	2,248,694		2,248,694	(6,829)	2,241,865			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pershing Estates #0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			33,902	33,902		33,902	3,698	37,600			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,083	11,083		11,083		11,083			32
33	Real Estate Taxes			70,381	70,381		70,381		70,381			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Corp.off.rent			60,000	60,000		60,000		60,000			36
37	**TOTAL Ownership**			175,366	175,366		175,366	3,698	179,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	4,948			4,948		4,948		4,948			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,214	75,214		75,214		75,214			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	4,948		75,214	80,162		80,162		80,162			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,624,590	100,966	778,666	2,504,222		2,504,222	(3,131)	2,501,091			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,473	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(3,423)	21		15
16	Personal Expenses (Including Transportation)	(1,775)	30		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,756)	21		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,131)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,131)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Pershing Estates

ID# 0022947

Report Period Beginning: 1-1-2004

Ending: 12-31-2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2004 **Ending:** 12-31-2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(650)	0	0	0	0	0	0	0	0	0	0	(650)	20
21	Clerical & General Office Expenses	(6,179)	0	0	0	0	0	0	0	0	0	0	(6,179)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,829)	0	0	0	0	0	0	0	0	0	0	(6,829)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,829)	0	0	0	0	0	0	0	0	0	0	(6,829)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2004 **Ending:** 12-31-2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,698	0	0	0	0	0	0	0	0	0	0	3,698	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,698	0	0	0	0	0	0	0	0	0	0	3,698	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,131)	0	0	0	0	0	0	0	0	0	0	(3,131)	45

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Contemporary Properties, Inc.	100	None		Striglos Companies	Decatur	Retail office products store

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Office expense	$ 2,117	Striglos Companies	100.00%	$ 2,117	$ 0	1
2	V	6	Maintenance supplies	197	Striglos Companies	100.00%	197	0	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,314			$ 2,314	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Nick Striglos	President	Management	28.00	None	18	45.00	Salary	$ 223,851	17-1	1
2	Jamie Kolovadis	Resident services	Resident serv.	24.00	None	32	100.00	Salary	20,301	17-1	2
3	Jamie Kolovadis	Resident services	Resident serv.	24.00	None			Exp. Reimb.	13,086	21-2	3
4	Jamie Kolovadis	Resident services	Resident serv.	24.00	None			Exp. Reimb.	3,900	14-2	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 261,138		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 2-31-2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Stifel Nicolaus/N.Striglos	X		Cash flow due to late IDPA	Open	12-28-01	300,000	514,000	Open	5.0000	11,083	6
7				payments--open line of								7
8				credit								8
9	TOTAL Facility Related						$ 300,000	$ 514,000			$ 11,083	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 300,000	$ 514,000			$ 11,083	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2004 **Ending:** 12-31-2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	55,325	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	62,853	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,528	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	62,853	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	70,381	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	47,137	8
	2000	50,972	9
	2001	54,206	10
	2002	54,206	11
	2003	55,325	12

Accrual based on amount paid in 2004 for 2003.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pershing Estates COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0022947

CONTACT PERSON REGARDING THIS REPORT Denise King

TELEPHONE (217) 429-2500 FAX #: (217) 429-0081

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07 07 34 351 013	N450.63' S950.63' W405.2'	$ 62,853.00	$ 62,853.00
2.		E652.2' SW1/4 SW1/4	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,853.00	$ 62,853.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,860 B. General Construction Type: Exterior Masonry Frame Metal Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility/yard	130,680	1976	$ 38,000	1
2					2
3	TOTALS	130,680		$ 38,000	3

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	137		1976	1973	$ 423,394	$	25	$	$	$ 423,394	4
5	10		1998	1998	470,332	12,059	25	18,813	6,754	112,878	5
6	Fixed equip.		1976	1976	70,012		VAR			70,012	6
7											7
8											8
	Improvement Type**										
9	Remodeling 1978			8/1/1978	16,657		VAR			16,657	9
10	Remodeling 1979			12/1/1979	8,066		VAR			8,066	10
11	47 cases floor tile			9/1/1982	1,410		7			1,410	11
12	Carpet & tile			9/1/1983	2,096		10			2,096	12
13	Floor tile			12/1/1984	312		7			312	13
14	1985 Improvements			6/1/1985	8,321	204	13		(204)	8,321	14
15	Floor & ceiling tile			6/10/1988	1,552		5			1,552	15
16	Water heater			1989	843		12			843	16
17	Flooring			1989	2,288		5			2,288	17
18	Storage shed			1989	454		20	23	23	372	18
19	Flooring			1989	2,919		5			2,919	19
20	Sliding glass door replacement			5/23/1989	830	26	11		(26)	830	20
21	Fire wall			11/14/1989	1,475	47	11		(47)	1,475	21
22	Laundry room service			12/14/1989	900		11			900	22
23	Wallpaper, carpet & floor tile			6/12/1990	2,749	34	5		(34)	2,749	23
24	Curtains, water heater, smoke eater, A/C			1990	19,559	246	10		(246)	19,559	24
25	Floor tile & A/C's			1991	5,147		7			5,147	25
26	Water heater, valves & pump			10/22/1991	4,974	158	15	332	174	4,370	26
27	Floor tile, carpet, A/C			1992	2,953		7			2,953	27
28	New roof--one wing			10/26/1992	5,500	175	9		(175)	5,500	28
29	Carpet & tile			1/29/1993	1,657		7			1,657	29
30	A/C & fire suppression system			8/24/1993	3,830		10			3,830	30
31	A/C & tile			1994	3,849		7			3,849	31
32	Quarry tile & patio door			1994	3,850	21	10	257	236	3,850	32
33	Carpet, tile, roof (one wing), A/C			1995	8,676	101	7		(101)	8,676	33
34	Water heaters			1995	6,029		15	402	402	3,941	34
35	A/C			6/28/1996	975		7			975	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting 108 yds.	9/20/1996	$ 1,603	$	7	$	$	$ 1,603	37
38	Floor tile & base	1997	982		7	37	37	982	38
39	New roof--one wing	1997	4,245	109	15	283	174	2,052	39
40	Partial roof replacement	1997	875	22	10	88	66	622	40
41	Carpeting 108 yds.	1997	1,142		7	96	96	1,142	41
42	Phone lines	1998	1,462	131	15	97	(34)	647	42
43	Light fixtures for sidewalk	1998	2,875	257	15	192	(65)	1,184	43
44	Phone lines, expand Muzak	1998	690	62	10	69	7	500	44
45	Furnaces	1998	2,475	221	7	354	133	2,419	45
46	A/C	1998	1,350	121	7	193	72	1,238	46
47	Backflow prevention device, materials adjustment	1998	4,976	444	15	332	(112)	2,103	47
48	Roof top furnace	1998	3,000	268	10	300	32	1,800	48
49	Balance of new addition	1999	25,316	649	25	1,013	364	5,402	49
50	Smoking room	1999	5,534	142	15	369	227	1,660	50
51	Handrails for smoking room	1999	853		15	57	57	342	51
52	A/C--furnace unit	2000	2,900		7	414	414	2,070	52
53	A/C unit & compressor	2000	4,000		7	571	571	2,570	53
54	Carpeting & vinyl	2000	1,593		7	228	228	1,007	54
55	TICA furnace & coil	2000	1,581		7	226	226	942	55
56	A/C--furnace unit	2000	2,900		7	414	414	1,691	56
57	New roof	2000	14,325	367	25	573	206	2,674	57
58	Handicapped access ramp	2001	11,018	280	25	441	161	1,360	58
59	A/C unit & compressor	2001	1,150		7	164	164	602	59
60	Tempstar furnace	2002	1,500	184	7	214	30	642	60
61	Goodman A/C 3.5 ton	2002	1,200	147	7	171	24	428	61
62	Goodman A/C 3.5 ton	2002	1,200	147	7	171	24	428	62
63	Simplex nurse call system	2002	24,800	98	15	1,653	1,555	3,582	63
64	Tempstar furnace w/coil	2002	1,469	180	7	210	30	437	64
65	Tempstar furnace w/coil	2002	1,454	178	7	225	47	450	65
66	Tempstar furnace w/coil (2)	2004	3,012	3,012	7	251	(2,761)	251	66
67	Tempstar furnace & coil	2004	1,515	1,515	7	162	(1,353)	162	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,214,604	$ 21,605		$ 29,395	$ 7,790	$ 764,373	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 31,353	$ 1,601	$ 4,039	$ 2,438	7-Jan	$ 19,240	71
72	Current Year Purchases	6,668	6,668	276	(6,392)	7	276	72
73	Fully Depreciated Assets	185,998	185	511	326	7	185,998	73
74								74
75	TOTALS	$ 224,019	$ 8,454	$ 4,826	$ (3,628)		$ 205,514	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	1999 Chevy Express van	2001	$ 10,343	$ 1,192	$ 2,069	$ 877	5	$ 6,552	76
77	Resident transportation	1994 Buick LeSabre	2003	4,542	474	908	434	5	1,211	77
78										78
79										79
80	TOTALS			$ 14,885	$ 1,666	$ 2,977	$ 1,311		$ 7,763	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,491,508	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,725	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,198	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,473	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 977,650	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Mercedes	$ 53,853	$ 1,775	$ 24,867	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 53,853	$ 1,775	$ 24,867	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Nurse aides hired are already certified.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2004 **Ending:** 12-31-2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12-31-2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 33,444	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	372,580		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee loans	1,927		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 407,951	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	519,756		11
12	Long-Term Investments			12
13	Land	38,000		13
14	Buildings, at Historical Cost	1,002,214		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	515,082		16
17	Accumulated Depreciation (book methods)	(1,011,805)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Reconcile cash/accrual	(322,987)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 740,260	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,148,211	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,593	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	514,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 563,593	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 563,593	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 584,618	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,148,211	$	48

***(See instructions.)**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 662,415	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 662,415	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	284,169	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(185,226)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 98,943	17
	B. Transfers (Itemize):		
18	**Reconcile cash/accrual**	(176,740)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (176,740)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 584,618	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,993,386	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,993,386	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	783	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 783	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,994,169	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	494,907	31
32	Health Care	940,660	32
33	General Administration	813,127	33
	B. Capital Expense		
34	Ownership	175,366	34
	C. Ancillary Expense		
35	Special Cost Centers	4,948	35
36	Provider Participation Fee	75,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,504,222	40
41	**Income before Income Taxes (line 30 minus line 40)****	489,947	41
42	**Income Taxes**	(205,778)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 284,169	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. Tax return is on cash b**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,298	2,410	$ 53,533	$ 22.21	1
2	Assistant Director of Nursing	2,435	2,571	44,435	17.28	2
3	Registered Nurses	1,838	2,028	37,848	18.66	3
4	Licensed Practical Nurses	14,255	14,895	214,056	14.37	4
5	Nurse Aides & Orderlies	42,545	44,252	332,521	7.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,202	2,292	24,118	10.52	9
10	Activity Assistants	4,705	4,813	26,958	5.60	10
11	Social Service Workers	6,285	6,480	98,045	15.13	11
12	Dietician					12
13	Food Service Supervisor	4,199	4,380	42,657	9.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,770	15,280	91,045	5.96	15
16	Dishwashers					16
17	Maintenance Workers	3,774	4,024	33,519	8.33	17
18	Housekeepers	15,152	15,787	115,714	7.33	18
19	Laundry					19
20	Administrator	2,258	2,394	73,948	30.89	20
21	Assistant Administrator					21
22	Other Administrative	2,024	2,160	46,711	21.63	22
23	Office Manager	2,024	2,160	32,817	15.19	23
24	Clerical	4,148	4,397	49,182	11.19	24
25	Vocational Instruction	972	972	223,851	230.30	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,866	4,091	31,049	7.59	28
29	Resident Services Coordinator	1,592	1,728	20,301	11.75	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Beautician	829	845	4,948	5.86	32
33	Other(specify) Res. Workers	9,204	9,204	27,334	2.97	33
34	TOTAL (lines 1 - 33)	141,375	147,163	$ 1,624,590 *	$ 11.04	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	208	$ 9,703	1-3	35
36	Medical Director	Flat fee	30,389	9-3	36
37	Medical Records Consultant	Flat fee	1,350	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,200	11-3	44
45	Social Service Consultant	40	1,200	12-3	45
46	Other(specify)				46
47	Psych. Consultant	Flat fee	710	12-3	47
48					48
49	TOTAL (lines 35 - 48)	288	$ 44,552		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nick Striglos	Management	28	$ 223,851
Sheila Herndon	Administrator	0	73,948
Denise King	Management	0	46,711
Jamie Kolovadis	Res. Services	24	20,301
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 364,811

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne & King	Accounting	$ 525
Sleeper, Disbrow etal	Accounting	4,000
AmEx Tax & Busn. Serv.	Accounting	2,400
Winston & Strawn	Legal	1,495
T.G. Bolen	Legal	3,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,920

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,281
Unemployment Compensation Insurance	33,559
FICA Taxes	115,411
Employee Health Insurance	23,094
Employee Meals	495
Illinois Municipal Retirement Fund (IMRF)*	
Christmas	889
TB tests	334
TOTAL (agree to Schedule V, line 22, col.8)	$ 207,063

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,243
Health Care Worker Background Check	1,810
(Indicate # of checks performed 132)	
Nursing Home Assn. Dues	7,022
Annual corporation fees	833
CLIA Lab Program	150
Macon Cty. Health Dept.--food license	375
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,433

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,978
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,978

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2004 Ending: 12-31-2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2004 **Ending:** 12-31-2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Ill. Council on Long Term Care $7022

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 75,214
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 261 Has any meal income been offset against related costs? Yes Indicate the amount. $ 2,611

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.